COUNTY OF SAN DIEGO, HEALTH & HUMAN SERVICES AGENCY
MENTAL HEALTH SERVICES

MENTAL HEALTH YOUTH TRANSITION SERVICES PLAN

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BACKGROUND AND PHILOSOPHY OF TRANSITION SERVICES FOR YOUTH

OVERVIEW AND PURPOSE

In recent year's youth, families, providers and the community have recognized that there are significant service gaps for youth as they transition from the Children's System of Care to the Adult System of Care. As a result, the Youth Transition Work Group was convened under the leadership of the Chief of Special Education, Children's Mental Health Services and the Clinical Director of Adult Mental Health Services. The work group met for approximately six months to identify the needs of youth, address service gaps, identify existing resources, and make recommendations to Children's Mental Health Services and the Adult Mental Health System. The work group researched the literature and best practices from San Mateo, Santa Clara and Pennsylvania programs to develop San Diego County Mental Health's Youth Transition Services Plan. This transition plan presents a blueprint for improved service delivery within our Mental Health Systems.

The provision of transition services has numerous challenges, such as barriers in effective interagency collaboration, a lack of appropriate services and community networks for youth and adults with disabilities. Attempts to transition youth into the adult mental health system typically occur when the youth is about 17.5 years of age. However, the treatment environment available is primarily designed for adults and is generally not tapered to meet the multiple specific developmental needs of young adults with mental disabilities. Likewise, the Children's Mental Health System recognizes the need to broaden its clinical attention to address transition issues starting at age 14, consistent with Individuals with Disabilities Education Act (IDEA) Amendments of 1997.

Transition services per IDEA, stipulates that an Individualized Education Plan (IEP), shall include transition needs related to the student's course of study beginning at age 14. This legislation coupled with clinical issues requires transition services component for students with mental health disabilities age 16 and older. The Children and Adult Mental Health Systems together with schools and other key partners need to further collaborate by developing policies and practices that will bridge and facilitate transition services for youth utilizing the mental health system.

Current exciting changes in San Diego's Mental Health System heighten the opportunity to improve service delivery. The Children's Mental Health System is moving toward a

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Gary Hubbard, Chief of Case Management & Conservatorship
Celeste Hunter, San Diego County Bar Association
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Piedad Garcia, Adult Mental Health Services, Co- Chair

OBJECTIVE

The objective of this plan is to develop specific strategies in the areas of access, service delivery, funding and training to provide youth and young adults with the necessary comprehensive mental health services to become self-sufficient and successful in their integration into community living. In order to achieve this, a strength based and consumer-centered practice shall be provided within a wraparound and a bio-psychosocial rehabilitation approach.

TARGET POPULATION CRITERIA

The specific criteria for the population served will include

- Title IX Chapter 11, Medi-cal Specialty Mental Health Services
- AB2726 Students
- Wards and Dependents meeting the above criteria
- Youth served in the Heartbeat, Lead Agency Initiative

TARGET POPULATION

In the mental health system there are approximately 3,342 opened youth cases between the ages of 14 and 21 year old per United Behavioral Health (UBH) report. From period 1/1/1999 to 6/30/99, youth in age categories 14 to 17 years of age represent the largest number of youth, approximately 2,400 clients and youth 18 to 21 year old represent approximately 930 clients. Of the total number of opened cases during this period the North Central Region and the Central region have a combined 49% of the youth , followed by the South Region with 16% , the East Region with 14%, North Coastal with 9% and North Inland with 7% of the sample

Youth in age categories 14 to 17 utilize an array of children's mental health services that include: individual/group/family therapy, medication management, case management, day treatment, residential care, acute care and long term care services. Youth 18 to 21 in the adult system of care utilize regional and/or countywide services to include: medication management, individual/group psychotherapy, case management, day rehabilitation, acute and long-term care, and employment/educational/housing services.

During this sample period, 429 youth received day treatment services, 338 received inpatient care and 3,334 youth received outpatient services. Note: Individual clients may have received more than one mode of service during the specified time period.

system of care development which includes a wraparound approach and the Adult Mental Health System is implementing an integrated bio-psychosocial rehabilitation model of service delivery. Both of these directions support the development of comprehensive transition services for our mental health clients. Services are to be developmentally and culturally appropriate, individualized, accessible, coordinated, community based and integrated with other public and private initiatives. In order to achieve this, the goal of the current plan is to ensure that:

1) Children and Adult Mental Health Systems continue their commitment to work jointly and in collaboration with other youth providers to share knowledge, expertise and resources, develop age appropriate services, improve coordination of services, and develop a seamless transition for Children's Mental Health clients entering the Adult Mental Health System.

2) A comprehensive clinical assessment focusing on transition of youth issues ~~that is youth~~ oriented ~~would~~ require information on clinical indicators and on related domains such as; need for independent living/social skills, self sufficiency skills, housing, educational and vocational needs and support in other related domains as part of their overall mental health service delivery.

3) Children's Mental Health Services develops a standardized process for addressing transition issues for youth being served in their mental health system.

4) Adult Mental Health Services develops a standardized process to address transition issues for youth entering into their mental health system.

Workgroup

MISSION

Children's Mental Health System and Adult Mental Health System, in partnership with youth will develop and implement age, developmental and culturally competent individualized mental health services for youth faced with transition issues in order to facilitate their transition from adolescence to an independent self sufficient adult.

use Wrap & PSR laws

PHILOSOPHY

To accomplish our mission, Children's Mental Health and Adult Mental Health are committed to jointly develop appropriate services and resources to meet the unique needs of youth in transition. Both the Children and Adult Mental Health Systems have agreed to modify existing clinical practice to more adequately address the specific needs of these youth. Additionally, both mental health systems shall work closely to develop a seamless referral process for youth requiring continued clinical services from the Adult Mental Health System. It is believed that with ongoing care coordination and continuous improvement we can successfully ensure service delivery that supports youth toward self-sufficiency and integration into the community.

The diagnostic picture of these youth is as follows:

DSM IV DIAGNOSIS	CLIENT TOTAL
Psychotic Disorder	144
Schizophrenia	164
Bipolar Disorder	153
Depressive Disorder	909
Anxiety/Panic Disorder	45
Attention Deficit Disorder	314
Oppositional/Conduct Disorder	603
Substance Related Disorder	116
Child Abuse/Maltreatment	183
No diagnosis/deferred	1,306
Other	245
TOTAL	3,342 *

* Primary Diagnosis (DSM IV, AXIS 1 code) was used to assign clients to diagnostic group. As a client may have multiple admissions with differing diagnosis, the sum of the subtotals may exceed the unduplicated client count totals. See attachment A.

Of the 3,342 opened cases, white youth have the highest representation in our system with 1,813 cases, African-American are represented by 543 youth, Mexican/other Hispanic/Latin American/Puerto Rican combined have 457 youth represented, Filipino 56 youth, Vietnamese 32 and Native American 25. During the data period 490 youth or 14% of youth were on 5150 holds.

The above data indicates a pressing need for a comprehensive and coordinated approach for youth utilizing a cross section of the mental health system. In order for the mental health system to address the needs of these youth, the Youth Transition Work Group recommends the development of a Youth Transition Implementation Team (YTIT). The purpose of the YTIT is to provide oversight on the implementation of this plan and ensure the development of a coordinated and seamless system of care.

Representatives from the Adult and Children's Mental Health systems shall lead and establish the YTIT. Membership will include representatives from both systems, representation from youth, social services, education, probation, and representatives from housing and vocational services.

I. CHILDREN'S MENTAL HEALTH SERVICES/TRANSITION ISSUES

As we evaluated the existing children's service delivery we identified several components in the system that can be modified to address the goals and objectives of this plan and they are as follows.

Children's Mental Health Services shall modify existing assessment forms to include transition issues in order to provide integrated services to meet the individual needs of each youth. Mental Health case managers will be responsible for coordinating transition services with schools for any mental health client who has an active IEP. In accordance with California Special Education Law 56345.1, schools are required to initiate at age 14, an updated annual statement of the transition service needs of the pupil receiving special education services. Early identification of transition issues related to the overall mental health needs of the client, allows for early intervention and increased ability to coordinate services with the educational system. The mental health assessment as well as linkages and referrals on behalf of the youth shall include a focus on clinical and self-sufficiency domains. Case managers and care coordinators in the mental health system shall provide care coordination with the multiple systems involved in the life of the youth.

The following services and program components is the minimum recommended service array in Children's Mental Health Services that shall be tailored to meet the needs of youth with diagnosable mental health needs.

A. Clinical and Behavioral Interventions

- Psychosocial Assessment
- Medication Management
- Individual/Group Therapy
- Family Therapy
- Substance Abuse Assessment/Treatment
- Case Management/Care Coordination
- Day Treatment
- Day Rehabilitation
- Residential
- Acute inpatient hospitalization and long term care
- Therapeutic Behavioral Services (TBS) accessible only to full scope Medi-cal beneficiaries under 21 years with serious emotional problems
- Supported education, employment and housing opportunities

B. Support Toward Self-Sufficiency

- Basic Life Skills /Social Skills
- Independent Living Skills
- Vocational/Educational Skills
- Psychoeducation
  -mental health/mental disorders
  -support groups
  -self-help
  -mentors

C. Multi-System Involvement

- Youth/Family
- Mental Health
- Social Services
- School/Community College
- Probation
- Department of Rehabilitation
- Housing
- Vocational
- Community

II. YOUTH TRANSITIONING TO THE ADULT SYSTEM OF CARE

A. Target Population

Youth in Children's Mental Health, meeting the target population criteria shall be identified by age 17.5 for transitioning services into the Adult Mental Health System.

B. Regional Points of Contact

To ensure a seamless transition into the Adult Mental Health System and appropriately coordinate the mental health care of youth transitioning into the Adult Mental Health System of Care, regional points of contact shall be established.

- A regionally identified coordinator in the Children's Mental Health System, which could be a Family Service Coordinator (FSC), shall coordinate the initial case conference with the Adult Mental Health Regional Program Coordinator (RPC) or designee from the Adult System of Care.
- The coordinators from each system will function as a liaison to facilitate service access in the region where youth will be residing. A regional case conference shall be convened for treatment disposition within two weeks of receipt of a referral. The youth his/her family or caretaker shall participate in

the initial case conference in addition to other appropriate resources identified by the client, family and Children or Adult Mental Health coordinators.

C. Referral Protocol

The following information is to be made available to the RPC or designee for review prior to the initial case conference. It is the responsibility of the RPC to include in the case conference, other adult system providers and the following information.

Psychosocial Assessment
Treatment/Service Plan
Medication Order
Individual Educational Plan (IEP)
Individual Transition Plan (ITP, when applicable)
Discharge Plan
Psychological Evaluations
Other relevant documentation

D. Access to Adult System of Care

Based on Medical Necessity, Title IX, requirements and Level of Care needed, a youth can be referred to the Fee-For-Service Network or Organizational Providers for mental health services. Care coordination is the responsibility of the assigned Family Service Coordinator. In the event that the youth does not have a FSC, the Organizational Provider currently providing services or case manager shall coordinate the transition into the adult system.

E. Denials and Appeals Process

Mental Health providers shall adhere to existing Adult Mental Health and Children's Mental Health policies.

III. YOUTH IN THE ADULT MENTAL HEALTH SYSTEM OF CARE

Mental health assessment and psychosocial rehabilitation services for youth in the Adult System of Care shall be chronologically, developmentally and culturally relevant to the youth needs. The following program components shall be modified to meet the needs of youth receiving mental health services in adult mental health programs.

A. Target Population:

Youth ages 18 to 24 years old who meet medical necessity and specialty mental health criteria under Title IX.

B. Service & Program Components

The following service and program components shall be modified to address the needs of youth in the Adult Mental System.

- Psychosocial Assessment, client plan and readiness assessment
- Medication Management
- Individual/group therapy/family therapy
- Day Rehabilitation
- Case Management
  Therapeutic Behavioral Services (TBS) accessible only to full scope Medi-cal beneficiaries under 21 years with serious emotional problems
- Acute inpatient hospitalization and long term care
- Crisis Plan
- Crisis Residential Services
- Supported education, employment and housing opportunities

Who will reccomend how to modify programs?

C. Youth Transition Team

It is recommended that each adult mental health program in the system establishes a Youth Transition Team (YTT) in their program. The YTT shall be a multi-disciplinary team that has or acquires experience in the treatment and provision of services for youth in the adult system. The team shall address the unique needs of youth in their program to include:

Psychiatric - Specialized medication needs, monitoring of medication and medication compliance. Behavioral management for high-risk youth.

Rehabilitation – Rehabilitative and Recovery focused treatment and services

Support – Family therapy, peer support, peer counseling, mentors

Linkages – Develops linkages with educational, housing, vocational, social and recreational community resources that are age and developmentally appropriate.

Assistance - with independent living skills, social skills and job seeking skills

IV. OUTCOMES & EVALUATION

The work groups recommends that the following outcome measures be monitored for compliance.

- Access to mental health services – develop access report for transitioning youth.
- Mental Health Assessment and readiness assessment – Yearly Site Review/Medical Record Review

- Access to housing/vocational/educational services – Yearly Site Review/Medical Record review.
- Client Plan/Goal attainment– Yearly Site Review/Medical Record Review
- Increase of community tenure – MIS Report
- Decrease of recidivism of inpatient services – MIS Report
- Client Satisfaction Survey – Annual survey by program or at time of discharge
- Tracking of cost per client – MIS Report

V. TRAINING AND COMMUNICATION PLAN

Communication of systemic, policy and procedural changes shall be provided via technical assistance, correspondence, at existing provider meetings and in specialized training. Additional strategies may include:

Development of a Youth Newsletter
Youth Transition Conference
Half Day Clinical Training Modules focusing on youth transition issues ✓
Youth Resource Directory

VI. FINANCIAL RESOURCE DEVELOPMENT

The following are areas considered by the work group to be viable avenues for financial resource development. The Children's and Adult Mental Health administration in collaboration with other partners shall pursue these and other funding options to expand youth transition services.

- EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
- Medi-Cal
- Tobacco Settlement Dollars
- Use of Realignment Dollars
- Foundation, Governmental and Research Grant

VII. IMPLEMENTATION TIMELINE

Specific steps shall be taken to ensure the implementation of the Youth Transition Plan.

By September 30, 2000

- Establish the Youth Transition Implementation Team
- Modify existing Mental Health Assessment forms to include identification of transition issues.
- Identify Children and Adult Regional Points of Contact
- Publish telephone list of all Regional Contacts
- Begin training and technical assistance on system changes, new policies, procedures and processes for existing County and Contract providers

Modify contract language to ensure adherence to Youth Transition Plan
Identification of financial resources; and pursue options
Begin development of one-day Youth Conference

- Begin development of half day clinical training modules

By June 30, 2001

- Continue to identify and pursue financial resources to expand youth transition services.
- Continue system wide training (Multi-Agency, Regional, Community)
- Implement half day training modules
- Monitor organizational providers on established outcomes.

By June 30, 2002

- Hold one-day Youth Transition Conference
- Establish regionally based services
- Develop Youth Transition Resource Directory

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